POS Value
SUMMARY OF BENIFITS

TUFTS Health Plan

With Tufts Health Plan's Point of Service (POS) plan, most of your care must be provided or authorized by your primary care physician in order to receive care at the authorized level of benefits. If you seek care without that authorization, you will be responsible for a deductible, after which Tufts Health Plan pays 80 percent for all covered services up to the out-of-pocket maximum. Once you reach the out-of-pocket maximum, you are covered in full for the reasonable charge for all covered services for the remainder of that calendar year. Your out-of-pocket maximum and deductible are listed on the other side of this document.

Effective December 1, 2003

Outpatient Medical Care*	Authorized	Unauthorized (after deductible)
Doctor's Office Visits	$15 per visit	$15 Per Visit then, Plan covers 80%
Routine Physical Exams	$15 per visit	$15 Per Visit then, Plan covers 80%
Well-Child Care	$15 per visit	$15 Per Visit then, Plan covers 80%
Specialist Care, Consultations	$15 per visit	$15 Per Visit then, Plan covers 80%
OB/GYN visits	$15 per visit	$15 Per Visit then, Plan covers 80%
Prenatal and Postnatal Care	$15 per visit	$15 Per Visit then, Plan covers 80%
Laboratory Tests, including Pap Smear	Covered in Full	Plan covers 80%
Diagnostic X-rays, including Mammograms	Covered in Full	Plan covers 80%
Injections and Immunizations	Covered in Full	Plan covers 80%
Speech and Short-term Physical/Occupational Therapy	$15 per visit	$15 Per Visit then, Plan covers 80%
Annual Routine Eye Exams	$15 per visit	$15 Per Visit then, Plan covers 80%
Spinal Manipulation (12 visits per calendar year)	$15 per visit	$15 Per Visit then, Plan covers 80%

Inpatient Hospital Care and Surgery**	Authorized	Unauthorized (after deductible)
Day Surgery	$0 per surgery	Plan covers 80%
Acute care for Illness or Injury, and Maternity Services	$150 per admission	$150/admit then, Plan covers 80%
Physician's Care while hospitalized	Covered in Full	Plan covers 80%
Surgery and Surgeon's Services while hospitalized	Covered in Full	Plan covers 80%
Newborn Care in hospital	Covered in Full	Plan covers 80%
Anesthesia while hospitalized	Covered in Full	Plan covers 80%
Medications while hospitalized	Covered in Full	Plan covers 80%
Nursing Care while hospitalized	Covered in Full	Plan covers 80%
X-ray and Lab Services while hospitalized	Covered in Full	Plan covers 80%
Intensive Care/Coronary Care while hospitalized	Covered in Full	Plan covers 80%
Radiation Therapy while hospitalized	Covered in Full	Plan covers 80%
Skilled Nursing In Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full	Plan covers 80%

Wellness Programs	
Membership at Network Fitness Facilities	Multiple discount options
Weight Watchers Weight Management Program	Discounted membership
Health Education (may require advance payment)	30% discount per program

** Semi-private room, unless private room is medically necessary. Preregistration required when not arranged by a network provider.

(OVER)

POS Value
SUMMARY OF BENIFITS

Mental Health*	Authorized	Unauthorized (after deductible)
Outpatient Care (up to 24 visits per calendar year)	$15 per visit	$15 Per Visit then, Plan covers 80%
Inpatient Care (Services provided through a Designated Facility Program for up to 60 days per calendar year)	$150 per admission	$150/admit then, Plan covers 80%

Substance Abuse**	Authorized	Unauthorized (after deductible)
Outpatient Care (Alcohol, Drug and Detoxification) (Tufts Health Plan pays up to $500 per calendar year)	$15 per visit	$15 Per Visit then, Plan covers 80%
Inpatient Care (Services provided through a Designated Facility Program for up to 30 days per calendar year)	$150 per admission	$150/admit then, Plan covers 80%

Emergency Care	
In Doctor's Office	$15 per visit
In Emergency Room	$50 per visit

Other Services	Authorized	Unauthorized (after deductible)
Durable Medical Equipment ($5,000 calendar year maximum, then at unauthorized level)	Plan pays 80%; Member pays 20%	Plan covers 80%
Ambulance (when medically necessary)	Covered in Full	Plan covers 80%

Deductible and Out-of-Pocket Maximum	Individual	Family
Annual Deductible	$250	$500
Annual Out-of-Pocket Maximum	$1,000	$2,500
Annual Day Surgery Copayment Maximum	$0	
Annual Inpatient Copayment Maximum	$300	

* Outpatient and inpatient mental health services are treated the same as any other medical condition when provided as required by law for the following: biologically-based mental disorders; certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. See your member benefit document for more information.

** Outpatient and inpatient substance abuse services are treated the same as any other mental health condition when provided in conjunction with treatment of a mental disorder. Treatment for detoxification is not subject to substance abuse day and visit limits listed in this document. See your member benefit document for more information.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as covered in the member's benefit document • Exams required by a third party, such as your employer, an insurance company, school or court • Any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any provider, member, service, supply or medication • Cosmetic surgery or any other cosmetic procedure except certain reconstructive procedures • Experimental or investigational drugs, services and procedures • Eyeglasses or contact lenses • Whole blood, packed red blood cells and blood donor fees • Drugs for use outside of hospital except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Long-term (more than 60 days) outpatient physical and occupational therapy services • Foot orthotics • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents

This is a summary only. Please refer to your member benefit document for more detailed information.
Copies are available by calling a member services coordinator at 800-843-1008.

Offered by Tufts Associated Health Maintenance Organization, Inc., a Tufts Health Plan company.